Practice Protocol

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Developed by the
Department of Health Services
Division of Behavioral Health Services

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Title
Practice Protocol, Co-Occurring Psychiatric and Substance Disorders, formerly known as “Practice Improvement Protocol #6.

What Do We Want to Achieve Through the Use of this Protocol?
To set forth Department of Behavioral Health Services (DBHS) expectations for recognition and treatment of co-occurring disorders.

Target Audience
This protocol will be made available to Tribal and Regional Behavioral Health Authorities (T/RBHAs) and behavioral health representatives who implement behavioral health services to behavioral health adults diagnosed with a co-occurring disorder.

Target Population
This protocol affects behavioral health individuals who have at least one mental health disorder as well as at least one alcohol or drug use disorder.

Background
Co-Occurring disorders may include any combination of one or more substance use disorders and mental health disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV-TR-IV). While these disorders may interact differently in any one person, at least one disorder of each type can be diagnosed independently of the other (Center for Substance Abuse Treatment (CSAT) TIP 42, 2005). It is estimated that 41-65% of people with serious mental illness (SMI) are also affected by substance abuse/dependence. Seven to 10 million individuals in the United States have at least one mental health disorder as well as an alcohol or drug use disorder. Research has yielded that dual disorders are linked to increased rates of relapse, violence, incarceration, homelessness and serious infections such as HIV and Hepatitis thus making prevention efforts and treatment challenging to the Nation’s public health system (Kessler et al., 1996; U.S. DHHS, 1999; SAMHSA Report to Congress, 2002; SAMHSA National Household Survey, 2002; Smith 2007).

Researchers have made strides over the last two decades by increasing the awareness of and employing evidence based treatment modalities for treatment of individuals with co-occurring disorders. Clinical findings indicate that treatment success is dependent upon timely screening, comprehensive assessment and integrated, client-centered treatment (Minkoff, 2000; SAMHSA Report to Congress, 2002).

Best practice guidelines are outlined in this document for assessment, treatment and psychopharmacology of individuals with co-occurring disorders. Before delineating the practice guidelines themselves, however it is important to describe some of the consensus-based recommended procedures.

Recommended Process/Procedures

1. Access to treatment- Access to assessment or to any service should not require individuals to be defined as mental health or substance disordered before arrival. Similarly, no one should be denied access to substance disorder assessment or treatment due to the presence of a co-morbid psychiatric disorder and/or the presence of a regime of non-addictive psychotropic medication (Minkoff, 2000; CSAT TIP 42, 2005).

2. Collaboration/Coordination- Both ongoing and episodic interventions require consistent collaboration and coordination between all involved in treatment i.e family, caregivers, peer support specialists, natural supports, and external systems. Collaboration with families and/or an individual's primary support systems should be considered an expectation for all individuals at all stages of change, as families and/or an individual's primary support system may provide significant assistance in developing strategies for motivational enhancement and contingent learning behavior, and in actively supporting participation in recovery-based programming to promote relapse prevention (Minkoff,2000). Communication and coordination of care between behavioral health providers, PCPs and Medicare providers must occur on a regular basis to ensure safety and positive clinical outcomes for persons receiving care.

3. Treatment appropriateness- Evidence based best practices for each separate disorder should be integrated into treatment. Interventions need to be matched to each diagnosis, phase of recovery, stage of treatment and stage of change (Prochaska & DiClemente,1982; Prochaska & DiClemente,1992). It is essential to be aware of cultural values and expectations that guide social interaction, and mental health/substance abuse treatment in their communities. Analysis of multiple program models indicate that treatment does not imply a single type of intervention, but that the formation of an empathetic, hopeful treatment relationship between the behavioral health representative and the individual is developed throughout treatment (Minkoff, 2001).

Assessment and Diagnosis of Co-Occurring Disorders

Clinical evaluation begins at the first point of clinical contact, regardless of the individual's presentation. Assistance should be provided in accessing services regardless of whether the client is appropriate for agency service. This "no wrong door" policy is expected be incorporated into the assessment process meaning individuals will be welcomed into treatment wherever they enter and should receive a person centered assessment that addresses both substance and mental health issues. A strength based approach that includes an appreciation of the person's racial and ethnic culture, gender, sexual orientation and traditions is recommended. One of the goals of the assessment process is to engage the individual in an ongoing process of evaluation as treatment progresses, during which diagnoses may be continually revised as new data emerges (Minkoff, 2001).

An accurate assessment for individuals with co-occurring disorders is complicated by the difficulty of distinguishing symptoms resulting from patterns that proceed from primary psychiatric illness from symptom patterns that are caused or exacerbated by primary substance use disorders. In many individuals with co-occurring disorders, both psychiatric and substance disorders are simultaneously and interactively contributing to symptoms. Consequently, diagnostic determination requires a careful approach to assessment often over a period of time, in order to best elucidate diagnosis accurately (Minkoff, 2001; Smith 2007).

CSAT TIP 42 (2005), Kanwischer (2001) and Minkoff, (2001) identify three fundamental principles of assessment:

1. Screening and Detection:

A variety of tools, such as checklists, are available for screening and evaluation. Assessment instruments can be used as a part of the evaluation process but should not constitute an assessment. Screening and evaluation are expected to include interaction with family, peers, case managers, probation officers, physicians and others as appropriate. Permission for interaction should always be obtained (see ADHS/DBHS Provider Manual Section 4.1, Disclosure of Behavioral Health Information). Drug testing can be a valuable tool in the screening process. Urine or saliva drug analysis can provide objective clinical data and may help determine treatment goals.

2. Diagnostic Determination:

Diagnosis of either mental illness or substance use disorder can rarely be established only by assessment of current substance use, mental health symptoms, or mental status exam. In most cases, diagnosis is more reliably established by obtaining a thorough biopsychosocial history (see ADHS/DBHS Provider Manual Section 3.9, Intake, Assessment and Service Planning). To establish a substance disorder consideration of past and current patterns of substance use needs to occur, while observing whether the patterns meet the criteria for substance dependent or substance abuse as defined in the DSM IV-TR IV. Similarly, the diagnosis of psychiatric disorders entails close examination of past and current symptoms in relation to the presence or absence of appropriate psychotropic medication and periods of substance abstinence or reduced use (CSAT TIP 9, 2005; CSAT TIP 42, 2005). The determination of SMI eligibility requires establishing a presumptive diagnosis of an SMI eligible psychiatric disorder, persistence of that disorder, and determining the functional incapacity of the person in accordance with state guidelines for SMI eligibility determination. More information can be found in the ADHS/DBHS Provider Manual Section 3.10, SMI Eligibility Determination.

Prior to treatment implementation, it is essential that the behavioral health representative evaluate where the individual is in terms of stage of recovery,

level of impairment and level of care required for successful treatment. Prochaska & Di Clemente's (1992) stage-of-change model identifies five stages of change: pre-contemplation, contemplation, preparation, action and maintenance (see Attachment A). In each of these stages, a person has to work through a different set of issues and tasks that relate to changing behavior. By identifying the stages readiness of change, appropriate treatment strategies can be employed. For example, a person in the pre-contemplation state is not yet considering making changes or is unable to. Strategies such as establishing rapport and building trust would be an appropriate intervention.

Level of impairment can be determined by the extent in which the individual requires care and support and in what areas. The capacity to learn recovery skills and participate in treatment must be measured. External contingencies such as legal and child protective services involvement must be considered as well as a close assessment of the resiliency factors that influence a person ability to recover. This includes determining a person's natural level of support, a person's abilities and strengths that can be highlighted and used to foster self-efficacy.

To effectively inform a level of care decision, an assessment of functional domains that include relapse potential, recovery environment, motivation, emotional/behavioral conditions and difficulties, biomedical conditions and complications and acute intoxication and/or withdrawal potential. These domains are included in the American Society of Addiction Medicine (ASAM) Level of Care Criteria, which can be accessed through at http://www.asam.org/. The ASAM 2R can effectively determine the level of care an individual needs and has the capacity to address comorbidity in level of care assessment (ASAM, 2001).

Treatment Interventions

Minkoff (2001) and Drake (2001) state, there is not one single correct intervention for individuals with co-occurring disorders. However several treatment elements are correlated with better treatment outcomes. Some of these elements are described below. Minkoff (2001) emphasizes the "importance of a flexible empathetic, hopeful continuing treatment relationship with an individual or team of clinicians, and a community of recovering peers, in which integrated treatment and coordination of care take place across multiple treatment episodes".

Integrated treatment implies that mental health and substance interventions are linked. Experts in co-occurring substance use and psychiatric disorders conclude that effective dual diagnosis treatment is comprised of interventions for both substance issues and mental health. Specifically, the treating behavioral health representative is expected to address both presentations. This concept is often referred to as "no wrong door policy". Specifically, a panel of experts write, "effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through

appropriate referral, no matter where he or she enters the realm of services" (CSAT TIP 42, 2005).

During the assessment process it is important to gage what treatment services are needed for both presentations and to assist the individual in accessing them through coordinated efforts. It is recommended that service providers stay engaged and follow-up to ensure that the individual is linked to appropriate services according to ones gender, cultural background, diagnosis, level of functioning, stage of preparedness to change and motivation level (Minkoff, 2001). Treatment should appear seamless to the behavioral health recipient with a unified philosophy, set of goals and recommendation.

When mental illness and substance disorders co-exist, both disorders are considered primary and intensive simultaneous interventions for each disorder is necessary. Treatment for co-occurring disorders can involve a variety of methods by which diagnosis-specific, evidenced-based strategies for each disorder are appropriately combined and coordinated. Treatment for known diagnosed mental illness must be initiated and maintained. Regimens such as, dialectic behavioral therapy for borderline personality disorder may be appropriately utilized to develop cognitive-behavioral skills to manage the mental illness, while applying similar skills to managing substance use and integrating direct substance disorder treatment interventions as well.

A plethora of information indicates that substance abuse treatment should incorporate individual and group interventions to help individuals make and implement better choices regarding substance use in relation to their mental illness. Addiction treatment for substance dependence for individuals with co-occurring disorders is fundamentally similar to addiction treatment for anyone, with abstinence as a goal, and with the need to develop specific skills for attaining and maintaining abstinence (Barreira & Espey et a., 2000; Ilgen & Moos, 2006; Moos et al., 2003; Mueser et al., 2003).

Treatment strategies also vary depending on the stage of change the individual is in. As described earlier, motivational enhancement techniques are best applied during the precontemplative stage of change to assist with movement towards contemplation. Miller and Rollnick (1995) suggest providing information about co-occurring disorders to evoke reasons to change, during the contemplation stage. Attachment A. identifies the five stages of change and recommended accompanying tasks.

Program Types:

Program Categories:

Before delineating programmatic characteristics, it is important to review co-occurring categories. Within any system of care, programmatic interventions can be categorized according to dual diagnosis capability. The American Addiction

Medicine's Taxonomy, breaks down program categories into three types: Addiction only Services (AOS), Dual Diagnosis Capable (DDC) and Dual Diagnosis Enhanced (DDE) (ASAM, 2001; Minkoff, 2000). These are described as follows:

1. Addiction Only Services (AOS):
   Programs that cannot accommodate adults who have psychiatric illnesses requiring ongoing treatment, however it stabilizes the illness and level of functioning of the client.

2. Dual Diagnosis Capable (DDC):
   Programs that have a primary focus on the treatment of substance-related disorders, but are also capable of treating adults who have a relatively stable co-occurring disorder. Provisions for comorbidity are integrated into screening, assessment, treatment planning and implementation, psychopharmacology, discharge planning and staff competency and training.

3. Dual Diagnosis Enhanced (DDE):
   Programs that are designed to treat adults who have more unstable or disabling co-occurring disorders in addition to their substance-related disorder.

Program Models:

Program descriptions vary in structure, level of intensity and treatment approaches. Before delineating programmatic models, it is imperative to highlight an evidence-based approach that can be used with any program model or intervention: motivational interviewing.

Motivational interviewing is a client-centered, direct method for enhancing motivation to change by exploring and resolving ambivalence. This style of interaction helps move individuals through stage change, seeks to create and amplify discrepancy between present behavior and broader goals. It works to develop a cognitive dissonance between where one is and where one wants to be. Four principles are essential to motivational interviewing: expressing empathy, rolling with resistance, developing discrepancy and promoting self-efficacy and change (CSAT TIP 35, 1999; Miller & Rollnick, 2002; Rollnick & Miller, 1995). Motivational interviewing is associated with improved consumer engagement and treatment retention (Carroll, et al., 2008)

Outpatient treatment models serve the greatest number of adults, making it imperative that these programs use the most effective services to reach the greatest number of persons with co-occurring disorders. Two outpatient models have shown to be valuable in treating co-occurring disorders: Assertive Community Treatment and Intensive Case Management.

A. Assertive Treatment (ACT):

ACT is a service-delivery model that provides comprehensive, intensive outreach activities and active and continued engagement with individuals. Services are provided through a multidisciplinary team that is trained in rehabilitation, case management, supportive services, and other key areas of treatment. Members include mental health and substance abuse individuals, case managers, nursing staff, psychiatric consultants, peer support workers and rehabilitation specialists. By working collaboratively, the team delivers a majority of the treatment rehabilitation and supportive services that the individual needs to sustain independence in the community. Unlike the traditional models where individuals are given resources to obtain independently, ACT goes to the individual as needed, 24-hours a day.

B. Intensive Case Management (ICM):

Intensive case management assists individuals in accessing basic needs and using brokered services. The model emphasizes developing trusting relationship with individuals through rapport building and engagement. Rigorous services are provided distinguishing this model from standard case management. A fundamental component of ICM is a smaller caseload per case manager, so that these services can be rendered (CSAT TIP 42, 2005).

C. Self-help:

Self help groups are based on the premise that a group of individuals who share a common behavior they identify as undesirable can collectively support each other and eliminate that behavior. They learn to accept their problem, and share their experiences, strengths, and hopes. The only requirement for attending a given self-help group is the desire to abstain from the problem behavior. This mutual, honest sharing affords participants a forum where often-stigmatized habits can be discussed in an accepting, trusting environment. It also provides a source of strategies to cope with the behavior and an opportunity to help others by sharing experiences and becoming a helper and a role model to others (CSAT TIP 42, 2005).

Most self-help groups follow some version of the 12-step model originally developed by the founders of Alcohol Anonymous (AA). One of the essential aspects of self-help, in contrast to other, more traditional forms of treatment for addictions, is the absence of "professional" involvement. Individuals come together to share with one another and to help one another in an active, self-enhancing role instead of being viewed as service recipients, a passive and often demeaning role. More information can be found on the AA website (http://www.aa.org).

D. Crisis intervention model:

Any type of mental health and/or substance use presentation is welcome in this model. Methods are used to offer immediate, short-term help to individuals. The purpose is to reduce the intensity of a person's emotional,

mental, physical and behavioral reactions to the presenting crisis and to facilitate moving the person to the previous level of functioning before the crisis. Behavioral health representatives employ active listening techniques and motivational interviewing to engage the individual. Careful screening and risk assessment are critical elements.

E. Inpatient Psychiatric Treatment:

Individuals who require acute psychiatric care and are in need of stabilization before returning to the community and may need intensive medically monitored 24-hour assistance. Inpatient psychiatric treatment is short term and aims to minimize symptoms and help the person reenter the community.

F. Partial Hospitalization:

Partial hospitalization can be an option once the person's psychiatric treatment stabilizes the presenting condition. Individualized and attentive services are given less than 24-hours a day. Individual and group therapy are provided as well as services to help the person maintain their abilities to function in the community. Because their treatment setting fosters the development of social networks that can help monitor the condition when not in the hospital the individual can return home at night and on weekends.

G. Detoxification Programs (Detox):

Detox programs can be categorized into two types: social and medical (CSAT TIP 45, 2006):

- Social detox usually requires no medication or medical personnel. 24-hour staff is available to the adult with the process usually taking 5-10 days. Some social detox programs offer peer support services and substance use education.
- Medical detox is recommended for individuals with poor health, with existing medical conditions and/or those who have the potential for severe withdrawal symptoms. Individuals are screened by medical personnel and closely monitored by hospital staff. Medications may be needed as a part of treatment.

H. Day Treatment:

These services are intermediate to long-term and specifically for psychiatric support. Varying degrees of stage specific curriculum and case management are offered. The primary consideration is to reduce or relieve the effects of mental health symptoms while providing support and training to foster the individual to live independently in the community.

I. Residential Programs:

Empirical evidence demonstrates the effectiveness of residential programs for persons with co-occurring disorders (CSAT TIP 42, 2005; Moggie, 1999). Residential treatment programs vary in length of stay, levels of intensity and psychiatric capability. Modified Therapeutic Communities (MTC) are drug free

residential settings that utilize peer influence to help individuals assimilate to social norms and develop effective social skills. Therapeutic community principles are adjusted to the person's needs, circumstance and treatment goal. MTCs are successfully being adopted in community residential programs to treat individuals with co-occurring disorders. A growing amount of research demonstrates the effectiveness of this model for people with co-occurring disorders. Outcomes show improved psychological functioning and decrease in substance use in men and women as well as culturally diverse populations (Alexander, 1996; Coletti et al.,1997; Rawlings & Yates, 2001).

J. Psychiatric Housing Programs:

These programs provide housing supports for individuals with psychiatric disabilities. As discussed previously, positive treatment outcomes are connected to matching individual needs and stage of change to clinical interventions. The Abstinence-expected ("dry") housing model is most appropriate for individuals with comorbid substance disorders who choose abstinence, and who want to live in a sober group setting to support achievement of abstinence. Such models may range from typical staffed group homes to supported independent group sober living.

Individuals who are not in the action stage of change, but recognize their need to limit use and are willing to live in supported settings where uncontrolled use by themselves and others is actively discouraged, might prefer a program model that focuses on eliminating dangerous behavior, rather than substance use per se. Such programs are referred to as abstinence-encouraged or "damp" housing.

"Wet" housing, also known as consumer-choice housing model recommends abstinence but does not penalize the person for using. Premotivational and motivational interventions are incorporated into the overall treatment approach. Independent supported housing with case management and peer supportive services are offered.

K. Intensive Outpatient Program

A structured treatment program with a well defined schedule that provides targeted interventions to address symptoms associated with primary or co-morbid substance dependence disorder. The program must provide evidence-based treatment, education, skill building and support services at least 9 hours per week. Services must be individualized as evidenced by the assessment and service plan. The program must include regular drug screening and must include an aftercare component for a defined period of time.

Psychopharmacology Practice Guidelines

Recognition of co-occurring disorder is essential to adequately addressing either disorder. Assessment for treatment should expect that all persons presenting might

have a co-occurring disorder, and that the assessment process may need to be ongoing in order to determine all diagnoses.

Treatment is expected to include appropriate intervention for all co-occurring disorders. Arbitrary barriers to treatment should be eliminated. Assessment for treatment of psychiatric disorder or substance disorder should not be made conditional on absence of either of the co-occurring disorders.

Each co-occurring disorder should receive specific appropriate intervention and treatment. Intervention strategy must be appropriately matched to individualized clinical assessment.

Informed consent must be obtained. Informed consent is an ongoing educational process geared to what the person receiving medication, family, and caregivers can comprehend, retain, and use. Parameters of informed consent include the diagnosis and target symptoms for which the medication is given, the intended benefits of treatment, the possible risks and side-effects and what to do if they occur, possible alternatives, possible results of not taking the treatment, and the possible course of treatment.

Safety in prescribing is paramount. Risk of prescription of medication as well as risk of not prescribing medication must be carefully considered. Proper monitoring of prescribed medications for effects, side effects, abuse, and misuse is expected.

Medications previously taken, outcome of prior treatment with medications, current medications, and effects and side effects of current medications should be documented. Family history of response to medications should be ascertained. Reproductive status of females of childbearing age should be determined, and medications, which may cause birth defects, avoided if possible in females who may become pregnant.

Many people with co-occurring psychiatric and substance abuse disorder also have concomitant medical disorder, such as liver disease, heart disease, lung disease, or metabolic disorder. Close communication and cooperation with the primary care physician and other health care providers is expected. Prescription of medication which could unfavorably interact with other prescribed medications or which could worsen medical disease generally should be avoided.

History of impulsive behavior or of overdose on medications and current and future risk of it should be considered carefully prior to prescription of medication likely to be lethal in overdose.

Risk of medication abuse, misuse or diversion should be carefully considered. Prescription beyond a detoxification period of medications with significant sedative potential or abuse potential should be reserved for selected persons with well-established abstinence demonstrating specific beneficial response without signs of misuse. Continued prescription of medications with abuse potential should occur only

with careful discussion of risks and benefits with the patient (and where indicated, the family or other caregivers) and documentation of expert consultation or peer review with a prescribing clinician experienced in treatment of substance dependency if possible.

Medications with abuse, misuse, or diversion potential include scheduled medications such as stimulants or benzodiazepines, medications with sedative effects such as some antipsychotic medications, and medications with significant anticholinergic properties.

Particular care should be taken in prescription of medication to persons receiving opiates for chronic pain or substance dependence, with avoidance of medications which could potentiate opiate effect and lead to death. This is particularly important for persons receiving methadone for chronic pain which has been implicated in sudden death.

Polypharmacy (prescription of multiple medications simultaneously) generally is not desirable. Polypharmacy increases likelihood of undesirable medication interaction, decreases likelihood of adherence, and makes it difficult to determine effects and side effects of each individual medication.

Medications with potential for side effects, particularly long term side effects such as movement disorders or metabolic disorders, should be given only when potential benefit outweighs potential risk. Close monitoring must occur, and may include such parameters as blood counts, lipid status, glucose status, hepatic status, renal status, thyroid status, heart rate, blood pressure, weight, waistline girth, and screening for abnormal involuntary movements. Presence or absence of side effects should be documented and any side effects present should be addressed.

Medications prescribed should be indicated for the patient's diagnoses and for documented target symptoms which then can be followed to assess effectiveness of medication. If prescribed medication is not effective for the intended target symptoms, it should be discontinued or a reason should be documented for continuing, such as inadequate length of trial or need for dosage increase.

The most common reason for medication failure is nonadherence. Laboratory study of blood medication level may be useful for medications in which such are available. Depot medications may be desirable for persons who are poorly adherent with medications, which may be available in depot form.

Another common reason for medication failure is ongoing substance abuse. A variety of modalities are available for monitoring for ongoing substance abuse, including report of the person receiving medication, report of other significant persons, and biologic fluid monitoring such as urine drug screening.

The first step in treatment is to establish medical and psychiatric safety in acute situations. Provision for safe detoxification and then maintenance of sobriety must be

made. A controlled environment for close monitoring to protect safety may be necessary during acute detoxification.

Medication for co-occurring psychiatric disorder should be directed to the treatment of known or probable psychiatric disorder. Some medications useful for co-occurring psychiatric disorder may also help promote sobriety, and may be considered preferentially.

Medication strategies to promote sobriety should be strongly considered, including medications, which have been to shown to increase likelihood of sobriety and are indicated for such.

Training and Supervision Recommendations

When training behavioral health representatives to employ evidence-based practices and develop clinical skills to work with an adult with co-occurring disorders, it is recommended that practitioners are able to demonstrate the following (CSAT TIP 42, 2005; Minkoff, 2001):

- A welcoming, empathetic, hopeful attitude in the provision of services to person with co-occurring disorders.
- Working knowledge of the needs and concerns of persons with co-occurring disorders as a special, unique population.
- Basic knowledge of etiology of mental health and substance use disorders and evidence-based treatment for co-occurring disorders.
- An understanding of change and recovery model use in the treatment of mental health and substance disorders.
- Practical knowledge on a range of crisis interventions and resolution approaches.
- The skills to complete basic screenings for co-occurring disorders and integrated, longitudinal, strength-based assessments.
- Ability to design, implement and ensure highly individualized, integrated treatment, discharge and continuing care plans.
- Able to identify stages of recovery and applying stage wise treatment.
- Network with other agencies to link behavioral health recipients to needed additional services.
- Knowledge and skills to facilitate the individual's experience of integrated, continuous and coordinated services.
- Facilitate individual learning and recovery through ongoing supportive engagement.
- Recognize the importance of treating the person as a whole using a multidimensional assessment that crosses the psychiatric and addiction treatment system.

Sound treatment depends on well-trained staff. Elements such as creating a supportive working environment that fosters professional development help build the infrastructure needed for quality clinical services (Powell & Brodsky, 2004). Successive quality clinical guidance as set forth in the Arizona Administrative Code R9-20-205, is recommended for each behavioral health representative providing services to persons with co-

occurring disorders. Through this clinicians can continue to acquire, maintain and enhance their direct practice skills. Some key elements Powell & Brodsky (2004) identify for effective clinical guidance include:

- Promoting professional development
- Assessing the delivery of high quality, ethical and culturally sound clinical interventions and performance
- Mentoring competencies
- Increasing awareness and abilities in best practices
- Monitoring workloads
- Providing feedback and recognition
- Supporting effective team work

For further information, the ADHS/DBHS Provider Manual Section 9.1, Training Requirements can be referred to.

Anticipated Outcomes

It is anticipated that by providing supportive, continuous, stage wise and integrated treatment over time to behavioral health individual diagnosed with co-occurring disorders the following will occur:

- Reduction of psychiatric symptomology, increased functioning and stability
- Improved outcomes, long and short term, of substance disorder
- Improved service delivery to persons with co-occurring disorders
- Reduction in high end service utilization

Co-Occurring Psychiatric and Substance Abuse Disorder

Desktop Guide

Key elements to remember about this best practice:

- Co-occurring disorders are the expectation, not the exception
- Recovery is a long-term process of internal change, in which progress occurs in stages.
- Treatment success derives from the implementation of an empathetic, hopeful, continuous treatment relationship.
- Integrated treatment treats both disorders simultaneously.
- Sound service delivery is dependent on well-trained staff who receives regular, quality supervision.
- There is no one type of co-occurring program or intervention.
- Treatment intervention must be individualized according to diagnosis, phase of recovery and level of functioning.

Benefits of Using This Best Practice:

- Applies the most current research and application available that demonstrates improvements for persons with co-occurring disorders.
- Greater success in achieving desired client outcomes.
- Better assessment and treatment matching.
- Person centered and individualized services.

Attachment A
Prochaska & DiClemente (1992)
Stages of Change Model

Stage of Change	*Characteristics*	*Techniques*
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1month	Identify and assist in problem solving re: obstacles Help patient identify social support Verify that patient has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with relapse

Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

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